House of Representatives

General Assembly

File No. 511

January Session, 2015

Substitute House Bill No. 5358

House of Representatives, April 8, 2015

The Committee on Human Services reported through REP. ABERCROMBIE of the 83rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT ESTABLISHING A BILL OF RIGHTS FOR RESIDENTS OF CONTINUING-CARE RETIREMENT COMMUNITIES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-520 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

As used in this section, sections **[**17b-520**]** 17b-521 to 17b-535, inclusive, as amended by this act, and sections 2 to 4, inclusive, of this act:

[(a)**]** (1) "Continuing-care contract" means an agreement pursuant to which a provider undertakes to furnish to a person not related by consanguinity or affinity to the provider, care and shelter in a facility or care at home with the right to future access to care and shelter in such facility and medical or nursing services or other health-related benefits for the life of a person or for a period in excess of one year, and which requires a present or future transfer of assets or an entrance

fee in addition to or instead of periodic charges, and the amount of the assets required to be transferred or the entrance fee is equal to or in excess of the amount set by the commissioner in regulations adopted pursuant to section 17b-533, as amended by this act;

[(b)**]** (2) "Entrance fee" means the total of any initial or deferred transfer to, or for the benefit of, a provider of a sum of money or other property made or promised to be made as full or partial consideration for acceptance or maintenance of a person as a resident pursuant to a continuing-care contract;

[(c)**]** (3) "Facility" means the place in which a provider undertakes to furnish shelter and care to a person pursuant to a continuing-care contract;

[(d)**]** (4) "Provider" means any person, corporation, limited liability company, business trust, trust, partnership, unincorporated association or other legal entity, or any combination of such entities, undertaking to furnish care and shelter in a facility or care at home with the right to future access to care and shelter in such facility and medical or nursing services or other health-related benefits pursuant to a continuing-care contract;

[(e)**]** (5) "Resident" means any person entitled to receive present or future shelter, care and medical or nursing services or other health-related benefits pursuant to a continuing-care contract, provided nothing in **[**sections 17b-520**]** this section, sections 2 to 4, inclusive, of this act or sections 17b-521 to 17b-535, inclusive, as amended by this act, shall affect rights otherwise afforded to residents while they are patients in health care facilities as defined in subsections (a), (b) and (c) of section 19a-490;

(6) "Residents council" means a board duly elected by residents at a facility to advocate for residents' rights and function as an advisory board to the provider with respect to resident welfare and interests;

[(f)**]** (7) "Affiliate of a provider" means any person, corporation,

limited liability company, business trust, trust, partnership, unincorporated association or other legal entity directly or indirectly controlling, controlled by or in common control with a provider;

[(g)**]** (8) "Offer" means an offer through either personal, telephone or mail contact or other communication directed to or received by a person at a location within this state as an inducement, solicitation or attempt to encourage a person to enter into a continuing-care contract and shall include any paid advertisement published or broadcast within this state, except for advertisements in periodicals where more than two-thirds of the circulation is outside this state but shall not include marketing or feasibility studies;

[(h)**]** (9) "Shelter" means a room, apartment, cottage or other living area in a facility set aside for the exclusive use of one or more persons pursuant to a continuing-care contract;

[(i)**]** (10) "Medical or nursing services or other health-related benefits" means services or benefits which shall include care in a nursing facility, priority admission to a nursing facility, home health care or assistance with activities of daily living, to which a resident becomes contractually entitled;

[(j)**]** (11) "Department" means the Department of Social Services;

[(k)**]** (12) "Commissioner" means the Commissioner of Social Services.

Sec. 2. (NEW) (*Effective July 1, 2015*) Each resident of a continuing-care retirement facility is entitled to:

(1) A voice in all decisions affecting the resident's health, welfare and financial security;

(2) Transparency regarding the financial stability of the provider operating the facility at which the resident resides;

(3) Timely notification of developments affecting the facility,

including, but not limited to: (A) Ownership changes of the provider operating the facility at which the resident resides, (B) a change in the financial condition of the provider operating the facility at which the resident resides, and (C) construction and renovation at the facility at which the resident resides;

(4) Independence in decisions regarding medical care and assisted living services; and

(5) Reasonable accommodations for persons with disabilities.

Sec. 3. (NEW) (*Effective July 1, 2015*) (a) Each provider shall develop a process for facilitating communication between residents and the personnel, management, board of directors and owner of the provider. Such process shall include, but not be limited to:

(1) Permitting residents at each facility to form a residents council;

(2) Allowing residents, including those who serve on the residents council, to serve as voting members of the provider's board of directors or other governing body if the rules applicable to such board or other governing body allow for resident membership and such board or other governing body approves such membership; and

(3) If the provider does not have a board of directors or similar governing body, or if a residents council is not established, then a provider shall seek comments from residents in advance of designing or adopting policies that affect the provider's ability to avert financial distress, as defined in section 17b-527 of the general statutes, as amended by this act.

(b) On or before January 1, 2016, and not less than every two years thereafter, each provider shall conduct a resident satisfaction survey at each facility. The results of the survey shall be made available to the residents council at each such facility, or to each resident, if there is no residents council. A copy of the survey results shall also be posted in a conspicuous location at each facility.

Sec. 4. (NEW) (*Effective July 1, 2015*) (a) A provider shall not prevent or otherwise infringe upon a resident's right to obtain treatment, care and services, including, but not limited to, home health and hospice care, from persons providing health care who have not entered into a contract with or are not affiliated with the provider, subject to the provider's policies and procedures for protecting the health and safety of residents.

(b) Residents at a continuing-care retirement facility receiving assisted living or skilled nursing services shall be entitled to all rights and protections afforded under the law, including the right to refuse medications and treatments. A provider shall not prevent or otherwise infringe upon a resident's right to participate, as fully and meaningfully as the resident is able, in making the decision about a permanent move to an assisted living facility or skilled nursing care unit. A provider shall inform family members designated by the resident of the resident's medical condition and care plan. A provider shall not prevent or otherwise infringe upon a resident's right to refuse medications and treatments.

(c) Each provider operating a facility shall make reasonable accommodations, in accordance with the Americans with Disabilities Act, 42 USC 12101, et seq., the Fair Housing Amendments Act of 1988, 42 USC 3601, et seq., and section 46a-64c of the general statutes to ensure that services and notices are accessible and communicated to residents who have hearing loss, low vision or other disabilities.

Sec. 5. Section 17b-521 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

No provider shall offer or enter into a continuing-care contract in this state or with any resident of this state or regarding any facility in this state and no change in ownership of such a facility shall be completed unless the provider or proposed owner, as the case may be, has (1) registered with the department by filing a (A) current disclosure statement that meets the requirements of section 17b-522, as amended by this act, (B) financial information **[**that meets the

requirements of**]** as required pursuant to section 17b-527, as amended by this act, and (C) a sworn statement of the escrow agent to the effect that the escrows required by sections 17b-524, as amended by this act, and 17b-525, as amended by this act, have been established; **[**, has**]** (2) received acknowledgment of such filing; and **[**has**]** (3) paid an annual filing fee of twenty-four dollars per residential unit operated by such provider. Acknowledgment of filing shall be furnished to the provider by the commissioner within ten business days of the date of filing. The commissioner may waive the requirements of this section if a change of ownership is proposed pursuant to section 17b-532 or a federal bankruptcy proceeding.

Sec. 6. Section 17b-522 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) Before the execution of a contract to provide continuing care, or before the transfer of any money or other property to a provider by or on behalf of a prospective resident, whichever shall occur first, the provider shall deliver to the person with whom the contract is to be entered into, or to that person's legal representative, a conspicuous statement notifying the prospective resident that:

(1) A continuing-care contract is a financial investment and his investment may be at risk;

(2) The provider's ability to meet its contractual obligations under such contract depends on its financial performance;

(3) **[**He**]** The prospective contract holder is advised to consult an attorney or other professional experienced in matters relating to investments in continuing-care facilities before he signs a contract for continuing care; and

(4) The department does not guarantee the security of his investment.

(b) Before the execution of a contract to provide continuing care, or before the transfer of any money or other property to a provider by or

on behalf of a prospective resident, whichever shall occur first, the provider shall deliver to the person with whom the contract is to be entered into, or to that person's legal representative, a disclosure statement. The text of the disclosure statement shall contain, to the extent not clearly and completely set forth in the contract for continuing care attached as an exhibit thereto, at least the following information:

(1) The name and business address of the provider and a statement of whether the provider is a partnership, corporation or other legal entity;

(2) The names of the officers, directors, trustees, or managing and general partners of the provider, the names of persons having a five per cent or greater ownership interest in the provider, and a description of each such person's occupation with the provider;

(3) A description of the business experience of the provider and of the manager of the facility if the facility will be managed on a day-to-day basis by an organization other than the provider, in the administration of continuing-care contracts or in the administration of similar contractual arrangements;

(4) A description of any matter in which the provider, any of the persons described in subdivision (2) of this subsection, or the manager has been convicted of a felony or pleaded nolo contendere to a felony charge, or held liable or enjoined in a civil action by final judgment, if the felony or civil action involved fraud, embezzlement, fraudulent conversion or misappropriation of property; or is subject to a currently effective injunction or restrictive or remedial order of a court of record, within the past five years has had any state or federal license or permit suspended or revoked as a result of an action brought by a governmental agency or department, rising out of or relating to business activity or health care, including, but not limited to, actions affecting the operation of a foster care facility, nursing home, retirement home, residential care home, or any facility subject to sections 17b-520 to 17b-535, inclusive, as amended by this act, sections

2 to 4, inclusive, of this act, or a similar statute in another state or country;

(5) A statement as to whether or not the provider is, or is affiliated with, a religious, charitable, nonprofit, or for-profit organization; the extent of the affiliation, if any; the extent to which the affiliate organization will be responsible for the financial and contractual obligations of the provider; and the provision of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of income tax;

(6) The location and a description of the physical property or properties of the provider, existing or proposed; and, if proposed, the estimated completion date or dates, whether or not construction has begun, and the contingencies subject to which construction may be deferred;

(7) The goods and services provided or proposed to be provided without additional charge under the contract for continuing care including the extent to which medical or nursing care or other health-related benefits are furnished;

(8) The disposition of interest earned on entrance fees or other deposits held in escrow;

(9) A description of the conditions under which the continuing-care contract may be terminated, whether before or after occupancy, by the provider or by the resident. In the case of termination by the provider, a description of the manner and procedures by which a decision to terminate is reached by the provider, including grounds for termination, the participation of a resident's council or other group, if any, in reaching such a decision, and any grievance, appeal or other similar procedures available to a resident whose contract has been terminated by the provider;

(10) A statement setting forth the rights of a surviving spouse who is a resident of the facility and the effect of the continuing-care contract

on the rights of a surviving spouse who is not a resident of the facility, in the event of the death of a resident, subject to any limitations imposed upon such rights by statute or common law principles;

(11) A statement of the effect of a resident's marriage or remarriage while in the facility on the terms of such resident's continuing-care contract;

(12) Subject to the provisions of subsection **[**(g)**]** (j) of this section, a statement of the provider's policy regarding disposition of a resident's personal property in the event of death, temporary or permanent transfer to a nursing facility, or termination of the contract by the provider;

(13) A statement that payment of an entrance fee or other transfer of assets pursuant to a continuing-care contract may have significant tax consequences and that any person considering such a payment or transfer may wish to consult a qualified advisor;

(14) The provisions that have been made or will be made by the provider for reserve funding and any other security to enable the provider to perform fully its obligations under continuing-care contracts, including, but not limited to, escrow accounts established in compliance with sections 17b-524, as amended by this act, and 17b-525, as amended by this act, trusts or reserve funds, together with the manner in which such funds will be invested and the names and experience of the persons making or who will make investment decisions; **[**. Disclosure shall include a summary of the information contained in the five-year financial information filed with the commissioner pursuant to section 17b-527; such summary shall set forth by year any anticipated excess of future liabilities over future revenues and shall describe the manner in which the provider plans to meet such liabilities;**]**

(15) **[**Audited and certified financial statements of the provider, including (A) a balance sheet as of the end of the most recent fiscal year, and (B) income statements for the three**]** The provider's financial

statements, including a balance sheet, income statement and statement of cash flow, associated notes or comments to these statements, audited by an independent certified public accounting firm for the two most recent fiscal years of the provider or such shorter period of time as the provider shall have been in existence;

(16) Subject to the provisions of subsection **[**(g)**]** (j) of this section, if the operation of the facility has not yet commenced, or if the construction of the facility is to be completed in stages, a statement of the anticipated source and application of the funds used or to be used in the purchase or construction of the facility or each stage of the facility, including:

(A) An estimate of such costs as financing expense, legal expense, land costs, marketing costs, and other similar costs which the provider expects to incur or become obligated for prior to the commencement of operations of each stage of the facility;

(B) A description of any mortgage loan or any other financing intended to be used for the financing of the facility or each stage of the facility, including the anticipated terms and costs of such financing;

(C) An estimate of the total entrance fees to be received from or on behalf of residents at or prior to commencement of operation of each stage of the facility; and

(D) An estimate of the funds, if any, which are anticipated to be necessary to fund start-up losses and provide reserve funds to assure full performance of the obligations of the provider under continuing-care contracts;

(17) Pro forma **[**annual income**]** cash flow statements for the facility for the next **[**five**]** three fiscal years**[**;**]** including a summary of projections used in the assumptions for such pro forma statements, including, but not limited to, anticipated resident turnover rates, average age of residents, health care utilization rates, the number of health care facility admissions per year, days of care per year and the

number of permanent transfers;

(18) The facility's current rate schedules for entrance fees, monthly fees, fees for ancillary services and current occupancy rates;

[(18)**]** (19) A description of all entrance fees and periodic charges, if any, required of residents and a record of past increases in such fees and charges during the previous **[**seven**]** five years;

[(19) For each facility operated by the provider, the total actuarial present value of prepaid healthcare obligations assumed by the provider under continuing-care contracts as calculated on an actuarially sound basis using reasonable assumptions for mortality and morbidity;**]**

(20) A statement that all materials required to be filed with the department are on file, a brief description of such materials, and the address of the department at which such materials may be reviewed;

(21) The cover page of the disclosure statement shall state, in a prominent location and type face, the date of the disclosure statement and that registration does not constitute approval, recommendation, or endorsement by the department or state, nor does such registration evidence the accuracy or completeness of the information set out in the disclosure statement;

(22) If the construction of the facility is to be completed in stages, a statement as to whether all services will be provided at the completion of each stage and, if not, the services that will not be provided listed in bold print; **[**.**]**

(23) A sworn statement of the applicable escrow agents to the effect that the escrows required by sections 17b-524, as amended by this act, and 17b-525, as amended by this act, have been established and maintained or an independent certified public accounting firm has verified such escrow accounts.

(c) Each provider operating a facility in this state shall make the

information filed with the department, pursuant to this section, available to each such resident for viewing during regular business hours and, upon request, shall provide such resident with a copy of the most recent filing with the department. Each provider shall notify each resident, at least annually, of the right to view the filings and of the right to a copy of the most recent filing.

(d) The registration of a facility pursuant to section 17b-521, as amended by this act, shall remain effective unless withdrawn by the provider or unless the provider fails to file the documents specified in this section within one hundred fifty days following the end of the first fiscal year in which such registration is filed. The provider shall file a revised disclosure statement at least annually with the commissioner. The provider shall also file a narrative describing any material differences between the pro forma income and cash flow statements filed pursuant to this section and the actual results of operations during the most recently concluded fiscal year. A provider may revise its previously filed disclosure statement at any time if, in the opinion of the provider, revision is necessary to prevent the disclosure statement from containing a material misstatement of fact or from omitting a material fact required to be included in the statement. Only the most recently filed disclosure statement, as amended from time to time, shall be deemed current for the purposes of sections 17b-520 to 17b-535, inclusive, as amended by this act, and sections 2 to 4, inclusive, of this act.

(e) The facility shall amend the most recently filed disclosure statement prior to undertaking major facility construction, renovation, or expansion or change of ownership to avoid a material misstatement or omission of a material fact.

[(c)**]** (f) (1) Not more than sixty nor less than ten days before the execution of a contract to provide continuing care, the provider shall deliver a current disclosure statement to the person with whom the contract is to be entered into or to that person's legal representative.

(2) Not more than sixty nor less than ten days before a person

occupies a continuing care facility, the provider shall deliver a revised and up-to-date disclosure statement to the prospective resident or to that person's legal representative, except that if there have been no revisions to the disclosure statement previously delivered pursuant to subdivision (1) of this subsection, the provider shall deliver a statement to the prospective resident or representative that there have been no revisions to the original disclosure statement.

[(d)**]** (g) The statement required under subsections (a) and (b) of this section shall be signed and dated by the prospective resident before the execution of a contract to provide continuing care or before the transfer of any money or other property to a provider by or on behalf of the prospective resident. Each such statement shall contain an acknowledgment that such statement and the continuing-care contract have been reviewed by the prospective resident or his legal representative. Such signed statements shall be kept on file by the provider for a period of not less than the term of the contract.

[(e)**]** (h) Each statement required under subsections (a) and (b) of this section and the continuing-care contract shall be in language easily readable and understandable in accordance with the provisions of subsections (a) and (b) of section 42-152.

[(f)**]** (i) A copy of the standard form or forms of the continuing-care contract used by the provider shall be attached as an exhibit to each disclosure statement.

[(g)**]** (j) The provisions of subdivisions (12) and (16) of subsection (b) of this section shall not apply to a continuing-care contract for the provision of care in a person's home.

[(h)**]** (k) The commissioner may adopt regulations in accordance with the provisions of chapter 54 to specify any additional information required in the disclosure statement.

Sec. 7. Section 17b-523 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) Each continuing-care contract shall provide:

(1) That the party contracting with the provider may rescind the contract by notifying the provider in writing by registered or certified mail of such rescission within thirty days following the execution of the contract; that in the event of such rescission, any money or property transferred to the provider shall be refunded, less (A) those costs specifically incurred by the provider or facility at the request of the resident and described in the contract or in an addendum thereto signed by the resident; and (B) a reasonable service charge, not to exceed the greater of one thousand dollars or two per cent of the entrance fees; and, if applicable, that the resident to whom the contract pertains shall not be required to move into the facility before the expiration of the thirty-day period;

(2) That if, after the thirty-day period, a resident dies before occupying a contracted-for living unit, or on account of illness, injury or incapacity is precluded from occupying a contracted-for living unit under the terms of the continuing-care contract, or a resident dies before the commencement of care under a continuing-care contract to provide care in such person's home, upon notice to the provider by registered or certified mail, the contract is automatically cancelled and the resident or the resident's legal representative shall receive a refund of all money or property transferred to the provider, less (A) those costs specifically incurred by the provider or facility at the request of the resident and described in the contract or in an addendum thereto signed by the resident; (B) a reasonable service charge not to exceed the greater of one thousand dollars, or two per cent of the entrance fee, and (C) if the contract includes occupying a living unit in a facility and the unit was actually available for occupancy, the usual monthly charge for that unit, prorated on a per diem basis, for the period beginning seven days after the execution of the contract and ending on the last day of the month in which the provider receives notice that the resident will not occupy the unit;

(3) **[**That**]** For contracts entered into after July 1, 2015, that if

construction of the facility has not yet begun, construction will not begin until a minimum number of living units, which shall not be less than one-half of the units in the facility [or if the construction is to be completed in stages, one-half of the units evidencing financial feasibility in accordance with section 17b-526,] or fifty per cent of any designated part or parts thereof determined by the commissioner have been presold, and a minimum deposit of [five per cent of the entrance fee per unit for all presold units or] ten thousand dollars per unit for all presold units [, whichever is less,] has been received by the provider. The requirements of this subdivision shall not apply to any continuing-care contract for the provision of care in a person's home.

(b) Each continuing-care contract shall also specify:

(1) The circumstances under which the resident will be permitted to continue to receive care and shelter in a facility or care at home with the right to future access to care and shelter in such facility and medical or nursing services or other health-related benefits, and other benefits under the continuing-care contract in the event of possible financial difficulties on the part of the resident;

(2) The terms and conditions under which a contract for continuing care may be cancelled by the provider or by the resident; and the conditions, if any, under which all or any portion of the entrance fee will be refunded in the event of cancellation of the contract by the provider or by the resident or in the event of the death of the resident prior to or following occupancy of a living unit, provided for contracts entered into after July 1, 2015, any refund shall be delivered to the resident or the resident's estate not later than two years from the date the living unit is vacated or when contractual conditions for releasing the refund have been met, whichever occurs first;

(3) The conditions under which a living unit occupied by a resident may be made available by the provider to a different or new resident other than on the death of the original resident;

(4) The manner in which the provider may adjust periodic charges

or other recurring fees and the limitations of such adjustments, if any, [and, if there is no such limitation, a clear statement that such increases may be made at the discretion of the provider] including, but not limited to, for contracts entered into after July 1, 2015, no periodic charges on other recurring fees may be increased unless a resident has been provided not less than thirty days' advance written notice of such fee increase.

Sec. 8. Section 17b-524 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) Prior to soliciting or entering into any contract for the provision of continuing care, the provider shall establish with a bank or trust company as an escrow agent, an entrance fee escrow pursuant to which the provider shall deposit with the escrow agent, within seventy-two hours of receipt by the provider, each entrance fee or portion of an entrance fee received by the provider from or on behalf of a resident prior to the date the resident is permitted to occupy a living unit in the facility. [If the prospective resident, as defined in section 17b-520, is a resident of this state at the time the continuing-care contract is signed, the] The bank or trust company serving as escrow agent for such fees received from such a resident shall have [its principal] a place of business in this state. The entrance fee escrow shall be subject to release as follows:

(1) If the entrance fee applies to a living unit that has been previously occupied in the facility, the entrance fee shall be released to the provider at the time the living unit becomes available for occupancy by the new resident, or shall be returned to the resident or the resident's personal representative under the conditions described in section 17b-523, as amended by this act, if the escrow agent has received written demand by registered or certified mail for return of the entrance fee prior to the release thereof to the provider;

(2) If the entrance fee applies to a living unit which has not previously been occupied by any resident, the entrance fee shall be returned to the resident or the resident's legal representative under the

conditions described in section 17b-523, as amended by this act, if the escrow agent receives written demand by registered or certified mail for return of the entrance fee prior to release thereof to the provider, or the entrance fee shall be released to the provider at the time all of the following conditions have been met:

(A) The sum of the entrance fees received or receivable by the provider pursuant to binding contracts for continuing care, plus the anticipated proceeds of any first mortgage loan or other long-term financing commitment, plus funds from other sources in the actual possession of the provider, equals or exceeds the sum of seventy-five per cent of the aggregate cost of constructing or purchasing, equipping and furnishing the facility plus seventy-five per cent of the funds estimated in the statement of anticipated source and application of funds submitted by the provider as part of its disclosure statement to be necessary to fund start-up losses of the facility plus seventy-five per cent of the amount of the reserve fund escrow required to be maintained by the provider pursuant to section 17b-525, as amended by this act;

(B) A commitment has been received by the provider for any permanent mortgage loan or other long-term financing described in the statement of anticipated source and application of funds included in the current disclosure statement on file pursuant to section 17b-522, as amended by this act, and any conditions of the commitment prior to disbursement of funds thereunder, other than completion of the construction or closing of the purchase of the facility, have been substantially satisfied; and

(C) If construction of the facility has not been substantially completed, all governmental permits or approvals necessary prior to the commencement of construction have been obtained; and a maximum price contract has been entered into between the provider and a general contractor responsible for construction of the facility; a bond covering the faithful performance of the construction contract by the general contractor and the payment of all obligations arising

thereunder has been issued by an insurer authorized to do business in this state with the provider as obligee; a loan agreement has been entered into by the provider for an interim construction loan in an amount, when combined with the amount of entrance fees then held in escrow under the provisions of this section plus the amount of funds from other sources then in the actual possession of the provider, that will equal or exceed the estimated cost of constructing, equipping and furnishing the facility; not less than ten per cent of the amount of the construction loan has been disbursed by the lender for physical construction or site preparation work completed; and orders at firm prices have been placed by the provider for not less than fifty per cent in value, including installation charges if applicable, of items necessary for equipping and furnishing the facility in accordance with the description set forth in the disclosure statement required by section 17b-522, as amended by this act; or if construction or purchase of the facility has been substantially completed, an occupancy permit covering the living unit has been issued by the local government having authority to issue these permits.

(b) The aggregate amount of entrance fees which may be released to the provider pursuant to subparagraph (A) of subdivision (2) of subsection (a) of this section prior to the date on which any reserve fund escrow required to be established under section 17b-525, as amended by this act, is established shall not exceed the aggregate amount of entrance fees then received or receivable by the provider pursuant to binding contracts for continuing care less the amount of the entrance fees received or receivable which may be required to be initially maintained in the reserve fund escrow.

(c) The provider shall provide each prospective resident who has signed a contract for continuing care with the name, address, and telephone number of the escrow agent and shall file a copy of the escrow agreement with the department.

(d) The provisions of this section shall not apply to any continuing-care contract for the provision of care in a person's home.

Sec. 9. Section 17b-525 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) Except as provided in section 17b-534, on and after the date any facility located in this state is first occupied by any resident, the provider shall establish and maintain on a current basis, in escrow with a bank, trust company, or other escrow agent having **[**its principal**]** a place of business in this state, a portion of all entrance fees received by the provider in an aggregate amount sufficient to cover: (1) All principal and interest, rental or lease payments due during the next **[**twelve**]** six months on account of any first mortgage loan or any other long-term financing of the facility; and (2) the total cost of operations of the facility for a one-month period, excluding debt service, rental or lease payments as described in subdivision (1) of this subsection and excluding capital expenditures. A provider may use funds in an account established by or pursuant to a mortgage loan, bond indenture or other long-term financing in its computation of the reserve amounts required to satisfy the provisions of this section, provided such funds are available to make payments when operating funds are insufficient for these purposes. To the extent that a provider is required pursuant to a mortgage loan, bond indenture or other long-term financing to maintain a certain number of days of cash on hand, cash amounts held pursuant to such a requirement may be applied toward the provider's computation of the operating reserve amount required to satisfy the provisions of this subsection. Notwithstanding any provision of this subsection, the commissioner may accept the terms or covenants regarding the establishment or maintenance of reserve or escrow funds or financial ratios associated with a mortgage loan, bond indenture or other long-term financing as an alternative to the reserve provisions set forth in this subsection. The escrow agent may release up to one-twelfth of the required principal balance of funds held in escrow pursuant to said subdivision not more than once during any calendar month, if the provider so requests in writing. The commissioner may authorize the escrow agent to release additional funds held in escrow pursuant to subdivisions (1) and (2) of this subsection, upon application by the provider setting forth the reasons for the requested

release and a plan for replacing these funds within one year; the commissioner shall respond within fifteen business days. If any escrow funds so released are not replaced within one year the escrow agent shall so notify the commissioner. A provider shall promptly notify the commissioner in the event such provider uses funds held in escrow pursuant to subdivisions (1) and (2) of this subsection. Upon written application by a provider, the commissioner may authorize a facility to maintain a reserve escrow or escrows in an amount less than the amounts set forth in this section, if the commissioner finds that the contractual liabilities of the provider and the best interests of the residents may be adequately protected by a reserve escrow or escrows in a lesser amount.

(b) No entrance fee escrows established or maintained under section 17b-524, as amended by this act, shall be subordinated to other loans or commitments of any kind. No reserve fund escrows established or maintained under this section shall be subordinated to other loans or commitments, other than first mortgage loans or other long-term financing obligations of the facility. No entrance fee **[**escrows or reserve fund escrows**]** escrow shall be **[**(1)**]** pledged as collateral **[**, (2)**]** for any loan or commitment, provided that a reserve fund escrow may be pledged as collateral for a first mortgage loan or other long-term financing obligation of the facility. No entrance fee escrows or reserve fund escrows shall be (1) invested in any building or **[**healthcare**]** health care facility of any kind, **[**(3)**]** (2) used for capital construction or improvements or for the purchase of real estate, or **[**(4)**]** (3) removed from the state if required to be maintained within this state. Interest on the reserve fund required under this section shall be payable to the provider.

(c) Any affiliate of a provider that controls any part of the reserve escrow funds is liable for the debts of the provider up to the amount of the provider's contribution to the fund plus any prorated interest the fund may earn.

Sec. 10. Section 17b-526 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) Construction of any facility or, if the construction of the facility is to be completed in stages, construction of any stage of the facility shall not begin until (1) fifty per cent of all the living units within the planned facility, or fifty per cent of any designated part or parts thereof determined by the commissioner **[**as evidencing financial feasibility in accordance with subdivision (2) of subsection (b) of this section,**]** have been presold, (2) a minimum deposit of **[**five per cent of the entrance fee per unit for all presold units or**]** ten thousand dollars per unit for all presold units **[**, whichever is less,**]** has been received by the provider, and (3) the thirty-day rescission period set forth in subdivision (1) of subsection (a) of section 17b-523, as amended by this act, has expired.

[(b) When the construction of a facility is to be completed in stages, construction of any stage shall not begin until (1) the financial feasibility of the designated part of the project to be constructed, maintained and operated as a facility prior to the construction, maintenance and operation of the remaining planned part or parts has been demonstrated to the commissioner by the filing of proof of committed construction financing or other documentation of financial feasibility deemed sufficient by the commissioner, and (2) the commissioner has issued a written notice stating that proof of committed construction financing or other documentation of financial feasibility deemed sufficient by the commissioner has been filed. The commissioner shall issue a written notice as to whether the proof or other documentation submitted is sufficient within twenty days of the filing of such proof or other documentation.

(c) Upon receipt of a notice of the commissioner stating that proof of committed construction financing or other documentation of financial feasibility filed pursuant to subsection (b) of this section is deemed insufficient, the provider shall have thirty days from the date of the issuance of such notice to file a written request for a hearing in accordance with chapter 54. The final decision of the commissioner

after a hearing shall be subject to appeal in accordance with section 4-183. Notwithstanding the provisions of subsection (f) of section 4-183, no stay of the final decision of the commissioner shall be granted pending the outcome of any appeal of such decision.**]**

(b) A provider shall give a resident, individually or through a residents council, not less than one hundred twenty days' advance written notice of any major construction, modification, renovation or expansion project. Such notice shall include, but not be limited to, (1) a project schedule and areas to be impacted, (2) funding needed for the project, (3) financing plans, (4) the expected amount of debt to be incurred, and (5) projected income from the project. If the provider plans to use any incurred debt to fund a project at a location other than the facility, the provider shall hold at least one meeting with residents to discuss the project and advise residents in writing of any impact on the resident's monthly service fee. The notice provisions in this section shall not apply to immediate renovation or construction necessary to address a public safety or health issue or issue related to a natural disaster, provided reasonable written notice of such project is provided to the residents council or to each resident.

Sec. 11. Section 17b-527 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

[(a) A provider operating a facility located in this state shall file with the department annually, in a form and manner prescribed by the commissioner, financial and actuarial information for each facility located in this state and operated by the provider or by a manager under contract to the provider. The commissioner shall prescribe the information to be filed which shall include but is not limited to the following: Financial statements including certified current balance sheets and certified income statements and pro forma statements for the next five years as provided in section 17b-522 and such information as is necessary to assess the actuarial soundness thereof; the basis for amortization assumptions for the provider's capital costs; the facility's current rate schedule; a statement of source and application of funds

for the five-year period beginning the year of initial filing pursuant to section 17b-521 or subsequent filing pursuant to section 17b-529; current and anticipated residential turnover rates; the average age of the residents for the next five years; healthcare utilization rates, including admission rates and days per one hundred residents by level of care; occupancy rates; the number of healthcare admissions per year; the days of care per year; and the number of permanent transfers. Financial and actuarial projections contained in such studies shall be determined on an actuarially sound basis using reasonable assumptions for mortality, morbidity and interest. Each provider operating a facility in this state shall make the information filed with the department pursuant to this subsection available to each such resident for viewing during regular business hours and, upon request, shall provide such resident with a copy of the most recent filing with the department. Each provider shall notify each resident, at least annually, of the right to view the filings and of the right to a copy of the most recent filing. The commissioner may adopt regulations in accordance with chapter 54 to prescribe financial and actuarial information to be filed pursuant to this subsection.**]**

[(b)**]** (a) A provider operating a facility in this state shall notify the commissioner in writing prior to refinancing its existing indebtedness or making any material change in its business or corporate structure.

(b) A provider shall notify the commissioner and the residents at all facilities it operates not less than three months in advance of any changes in ownership of the provider. The commissioner may excuse a provider from the requirements of this section, on a case-by-case basis, if reasonable written notice of the change in ownership is also provided to each residents council at each facility operated by the provider or, if no residents council exists, to each resident.

(c) A provider shall provide residents at all facilities it operates not less than thirty days' advance written notice of increases in any monthly service fees charged to the residents, along with an explanation of such increases and an opportunity for dialogue and

comments from residents concerning such increases.

[(c)**]** (d) The commissioner may require a provider operating a facility in this state to submit such information as the commissioner requests if the commissioner has reason to believe that such facility is in financial distress. The commissioner may require a provider constructing a facility in this state to submit such information as the commissioner requests if the commissioner has reason to believe that such facility is at risk of being in financial distress. "Financial distress" means the issuance of a negative going concern opinion, or failure to meet debt service payments, or drawing down on debt service reserve.

[(d)**]** (e) The commissioner may adopt regulations in accordance with chapter 54 to prescribe additional conditions that constitute financial distress. To the extent that a provider seeks modification, waiver or extension of any of the provider's material financial covenants or material payment terms under a mortgage loan, bond indenture or other long-term financing agreement, the provider shall report such requests in writing to the commissioner with a copy to the applicable residents council of the facility or facilities operated by the provider in this state, not later than seven business days after making such requests. If the commissioner determines that a facility is in financial distress, the provider of that facility shall, pursuant to a process established by the commissioner, propose a remediation plan to improve the provider's financial health. Such remediation plan shall be submitted for approval and supervision by the commissioner and shall be disclosed to the residents council of the provider. The provider shall file regular reports with the commissioner and the provider's residents council, regarding its progress in meeting its approved remediation plan. Such reports shall be filed on a quarterly basis or on an alternative schedule established by the commissioner.

Sec. 12. Subsection (c) of section 17b-529 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(c) Nothing contained in sections 17b-520 to 17b-535, inclusive, as

amended by this act, or sections 2 to 4, inclusive, of this act shall be construed to limit the remedies a person has under any other provision of law.

Sec. 13. Section 17b-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

Any person who wilfully and knowingly violates any provision of sections 17b-520 to 17b-535, inclusive, as amended by this act, or sections 2 to 4, inclusive, of this act shall be fined not more than ten thousand dollars or imprisoned for a period not to exceed one year, or both.

Sec. 14. Section 17b-531 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

(a) The commissioner, or any agent authorized by the commissioner, may conduct investigations within or outside of this state as the commissioner deems necessary to determine whether any person has violated any provision regarding the registration, disclosure and escrow provisions relating to continuing-care contracts or any regulation adopted pursuant to section 17b-533, as amended by this act, or to aid in the enforcement of sections 17b-520 to 17b-535, inclusive, as amended by this act, sections 2 to 4, inclusive, of this act or in the prescribing of regulations under said sections. The commissioner, or any agent authorized by the commissioner, shall have the power to conduct any inquiry, investigation or hearing pursuant to the provisions of this section relating to continuing-care contracts and shall have the power to administer oaths and take testimony under oath relative to the matter of inquiry or investigation. At any hearing ordered by the commissioner, the commissioner or such agent having authority by law to issue such process may subpoena witnesses and require the production of records, papers and documents pertinent to such inquiry. If any person disobeys such process or, having appeared in obedience thereto, refuses to answer any pertinent question put to **[**him**]** such person by the commissioner or **[**his**]** the commissioner's authorized agent or to produce any records

and papers pursuant thereto, the commissioner or [his] the commissioner's agent may apply to the superior court for the judicial district of Hartford or for the judicial district wherein the person resides or wherein the provider or the facility is located, or to any judge of said court if the same is not in session, setting forth such disobedience to process or refusal to answer, and said court or such judge shall cite such person to appear before said court or such judge, and upon appropriate order, to show cause why answer to such question or production of such records should not be made.

(b) If as the result of any investigation relating to continuing-care contracts, the commissioner determines that any provider has violated any provision of sections 17b-520 to 17b-535, inclusive, as amended by this act, or sections 2 to 4, inclusive, of this act the commissioner may, notwithstanding the provisions of chapter 54, request the Attorney General to seek a temporary or permanent injunction and such other relief as may be appropriate to enjoin such provider from continuing such violation or violations. If the court determines that such violation or violations exist, it may grant such injunctive relief and such other relief as justice may require and may set a time period within which a provider shall comply with any such order. Any appeal taken from any permanent injunction granted under this section shall not stay the operation of such injunction unless the court is of the opinion that great and irreparable injury will be done by not staying the operation of such injunction. If the commissioner determines that any person has violated the provisions of sections 17b-520 to 17b-535, inclusive, as amended by this act, or sections 2 to 4, inclusive, of this act, the commissioner may request the Attorney General to seek restitution or damages and such other relief as may be appropriate on behalf of any person injured by such violation.

Sec. 15. Section 17b-533 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

The commissioner shall adopt regulations in accordance with the provisions of chapter 54 to carry out the provisions of sections 2 to 4,

inclusive, of this act, and sections 17b-520 to 17b-535, inclusive, as amended by this act, including the prescribing of the minimum amount of assets to be transferred or entrance fee which shall subject a continuing-care contract to the provisions of said sections.

Sec. 16. Section 17b-535 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2015*):

There shall be an Advisory Committee on Continuing Care appointed by the commissioner that shall meet not later than August 1, 2015, and at least quarterly thereafter. The advisory committee shall be comprised of professionals such as accountants, actuaries, and insurance representatives; representatives of the continuing-care industry; a designee of the Commissioner of Social Services, who shall report to the commissioner after every meeting on actions taken and recommendations made at the meeting; and others knowledgeable in the field of continuing care and familiar with the provisions of sections 17b-520 to 17b-535, inclusive, as amended by this act, and sections 2 to 4, inclusive, of this act. The advisory committee shall assist the continuing-care staff in its review and registration of functions, shall report to the commissioner on developments in the field, any special problems associated with continuing care, and concerns of providers and residents, and, when appropriate, shall recommend changes in relevant statutes and regulations.

Sec. 17. Section 17b-528 of the general statutes is repealed. (*Effective July 1, 2015*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2015*	17b-520
Sec. 2	*July 1, 2015*	New section
Sec. 3	*July 1, 2015*	New section
Sec. 4	*July 1, 2015*	New section
Sec. 5	*July 1, 2015*	17b-521
Sec. 6	*July 1, 2015*	17b-522
Sec. 7	*July 1, 2015*	17b-523

Sec. 8	*July 1, 2015*	17b-524
Sec. 9	*July 1, 2015*	17b-525
Sec. 10	*July 1, 2015*	17b-526
Sec. 11	*July 1, 2015*	17b-527
Sec. 12	*July 1, 2015*	17b-529(c)
Sec. 13	*July 1, 2015*	17b-530
Sec. 14	*July 1, 2015*	17b-531
Sec. 15	*July 1, 2015*	17b-533
Sec. 16	*July 1, 2015*	17b-535
Sec. 17	*July 1, 2015*	Repealer section

Statement of Legislative Commissioners:

In Section 3(a)(3), "resident council" was changed to "residents council" for internal consistency; in Section 4(c), "42 USC 1997" was changed to "42 USC 3601" for accuracy; in Section 6(b)(17), "health care admissions" was changed to "health care facility admissions" for clarity; in Section 7, "effective date of this section" was changed to "July 1, 2015" for clarity; in Section 9, "this section" was changed to "the provisions of this section" and "this subsection" was changed to "the provisions of this subsection" for internal consistency; in Section 10, "related to" was changed to "issue related to" for clarity; and in Section 11, "provider must report" was changed to "provider shall report" for internal consistency.

HS *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact: None

Municipal Impact: None

Explanation

The bill makes various changes for continuing care providers, including disclosure requirements for continuing care providers to the Department of Social Services and facility residents, which do not result in a fiscal impact to the state or municipalities.

The Out Years

State Impact: None

Municipal Impact: None

OLR Bill Analysis

sHB 5358

AN ACT ESTABLISHING A BILL OF RIGHTS FOR RESIDENTS OF CONTINUING-CARE RETIREMENT COMMUNITIES.

SUMMARY:

This bill requires continuing care facility providers to give residents advance notice of major construction, ownership change, and increases in monthly service fees. It allows residents of continuing care facilities to form residents councils, defined in the bill as boards elected by residents to advocate for residents' rights and also function as an advisory board to the provider with respect to resident welfare and interests. The bill also stipulates rights and entitlements of continuing care residents.

The bill adds to continuing care contracts new requirements regarding refunds, new construction, and periodic charges and fees.

The bill also decreases the amount of funds continuing care providers must keep in escrow and allows providers to use funds in accounts for mortgage loans, bond indentures, or other long-term financing in their computation of required reserve amounts for the escrow account, in certain circumstances.

The bill also makes several changes to requirements for information providers must file with the Department of Social Services (DSS). It adds many of these existing requirements to the disclosure statement a person entering into a continuing care contract must receive.

EFFECTIVE DATE: July 1, 2015

RESIDENT PROTECTIONS

Under the bill, residents of continuing care facilities are entitled to:

1. a voice in all decisions affecting the resident's health, welfare, and financial security;

2. transparency regarding the financial stability of the provider operating the facility at which the resident resides;

3. timely notification of developments affecting the facility, including (a) ownership changes of the provider operating the resident's facility; (b) change in the financial condition of the provider operating the resident's facility; and (c) construction and renovation at the facility;

4. independence in decisions about medical care and assisted living services; and

5. reasonable accommodations for persons with disabilities.

The bill prohibits providers from infringing upon a resident's right to obtain treatment, care, and services, including home health and hospice care, from those providing health care who are not under contract or affiliated with the provider, subject to the provider's policies and procedures for protecting the resident's health and safety. The bill stipulates that residents getting assisted living or skilled nursing services are entitled to all rights and protections by law, including the right to refuse medications and treatments. The bill prohibits providers from infringing on a resident's right to participate, as much as the resident is able, in decision making about permanent moves to an assisted living facility or skilled care unit. Providers must inform designated family members of the resident's medical condition and care plan.

The bill requires providers to make reasonable accommodations in accordance with the federal Americans with Disabilities Act and other federal and state laws to ensure that services and notices are accessible and communicated to residents who have hearing loss, low vision, or other disabilities. (By law, these accommodations are already required.)

PROVIDER COMMUNICATION WITH RESIDENTS

The bill requires each provider to develop a process for facilitating communication between residents and the personnel, management, board of directors, and owner of the provider. Such process must include:

1. permitting residents at each facility to form a residents council, defined as a board duly elected by residents at a facility to advocate for residents' rights and function as an advisory board to the provider with respect to resident welfare and interests and

2. allowing residents, including those who serve on the council, to serve as voting members of the provider's board of directors or other governing body if the rules allow for resident membership and the board or governing body approves.

If the provider has no board of directors or similar governing body, or if resident council is not established, then the provider must seek comments from residents before designing or adopting policies affecting its ability to avert financial distress.

The law defines "financial distress" as failure to meet debt service payments, drawing down on debt service reserve, or the issuance of a negative going concern opinion (i.e., a report from an auditor or accountant expressing doubts about the company's ability to stay in business).

Major Construction

The bill also requires providers to give residents, individually or through their council, at least 120 days advance notice of any major construction, modification, renovation, or expansion project. The notice must include at least:

1. a project schedule and areas to be impacted,

2. funding needed for the project,

3. financing plans,

4. the expected amount of debt to be incurred, and

5. projected income from the project.

Under the bill, if the provider plans to use any incurred debt to fund a project at a location other than the facility, the provider must hold at least one meeting with residents to discuss the project and advise them in writing of any impact on their monthly service fee. Under the bill, these notice requirements do not apply to immediate renovation or construction necessary to address a public safety or health issue or related natural disaster, except that the provider must provide reasonable written notice of such projects to the resident council or each resident.

Change in Ownership

The bill requires providers to notify DSS and residents at all facilities they operate not less than three months before any changes in ownership. The bill allows DSS to excuse providers from this requirement on a case-by-case basis, if reasonable written notice of the ownership change is also provided to each resident council or, if no resident council exists, to each resident.

Monthly Service Fee Increases

The bill requires providers to provide residents at all facilities they operate at least 30 days advance written notice of increases in any monthly service fees charged to residents, along with an explanation for such increases and an opportunity for dialogue and comments from residents concerning such increases.

Resident Satisfaction Surveys

By January 1, 2016, and at least every two years thereafter, the bill requires providers to (1) conduct resident satisfaction surveys at each facility (2) make survey results available to the facility's resident council (or to each resident if there is no council), and (3) post a copy of the results at a conspicuous location at each facility.

PROVIDER REGISTRATION WITH DSS

By law, providers must register with DSS by filing a disclosure statement (see next section), financial information, and a sworn statement on required escrows. Under the bill, provider registration with DSS remains effective unless the provider (1) withdraws or (2) fails to file documents required as part of its disclosure statement within 150 days of the end of the first fiscal year in which it registers. The bill requires providers to file (1) revised disclosure statements annually with DSS and (2) a narrative describing any material differences between the pro forma income and cash flow statements and the actual results of operations during the most recently concluded fiscal year.

Under the bill, providers may revise their previously filed disclosure statement at any time if they believe revision is needed to prevent the statement from containing a material misstatement of fact or omitting required information. Under the bill, DSS must only deem the most recently filed disclosure statement as current. The bill requires facilities to amend the most recently filed disclosure statement prior to undertaking major facility reconstruction, renovation or expansion, or ownership change in order to avoid misstatement or omission of required information.

DISCLOSURE STATEMENT REQUIREMENTS

Current law requires providers operating facilities in the state to:

1. file with DSS certain financial and actuarial information for each of their facilities with DSS;

2. make this information available to residents for viewing during regular business hours and, upon request, provide residents with a copy of the provider's most recent filing; and

3. notify each resident, at least annually, of the right to view the filings and get a copy of the most recent filing.

The bill instead requires much of this information to be included in

the provider's disclosure statement, which, under the bill, must also be filed with DSS. The bill requires that providers (1) make information filed with DSS as part of the disclosure statement available to residents for viewing during regular business hours and, upon request, provide residents with a copy of the provider's most recent filing; and (2) notify each resident, at least annually, of the right to view disclosure statement filings and right to a copy of the most recent filing. By law, providers must deliver the disclosure statement to prospective residents before executing a contract or transferring money or property to a provider by or on behalf of a prospective resident.

Rate Schedules and Fees

Current law requires providers to file the facility's current rate schedule and its occupancy rates with DSS. The bill instead requires the disclosure statement to include the facility's current rate schedules for entrance fees, monthly fees, fees for ancillary services, and current occupancy rates.

The bill reduces, from seven to five years, the record of past increase of entrance fees and periodic charges required in the disclosure statement.

Financial Information

Current law requires the disclosure to include audited and certified financial statements of the provider, including a balance sheet as of the end of the most recent fiscal year and income statement for the three most recent fiscal years, or shorter period if the provider has existed for less than three years. The bill eliminates those requirements and instead requires the disclosure statement to include the provider's financial statements, including a balance sheet, income statement, and statement of cash flow, associated notes, or comments to these statements, audited by an independent certified public accounting firm for the two most recent fiscal years (or shorter time, if provider has existed less than two years).

Current law requires the facility to file with DSS financial

statements, including certified current balance sheets and certified income and pro forma statements for the next five years. Current law also requires the disclosure statement to include pro forma annual income statements for the facility for the next five fiscal years. The bill eliminates those requirements and instead requires the disclosure statement to include pro forma cash flow statements for the facility for the next three fiscal years.

Current law requires providers to file with DSS the (1) number of healthcare admissions per year, (2) days of care per year, and (3) number of permanent transfers. The bill instead requires this information in the disclosure statement as part of a summary of projections used in the assumptions for the pro forma statements. The bill similarly moves to the disclosure statement summary information on anticipated resident turnover rates, average age of residents, and health care utilization rates. But the bill removes from it explicit requirements (1) for current residential turnover rates, (2) that average age information is for the next five years, and (3) that healthcare utilization rates include admission rates and days per 100 residents by level of care.

The bill eliminates a requirement that the provider provide a statement of the source and application of funds for the five-year period beginning when it registers with DSS. It also removes a requirement to include in the disclosure statement a summary of this information that sets forth by year any anticipated excess of future liabilities over future revenues and describes how the provider plans to meet such liabilities. The bill also eliminates a requirement that the provider file with DSS a basis for amortization assumptions for its capital costs.

The bill requires the disclosure statement to include a sworn statement by the applicable escrow agents stating that required escrows have been established and maintained or an independent certified accounting firm has verified such escrow accounts.

The bill eliminates a requirement that the disclosure statement

include, for each facility operated by the provider, the total actuarial present value of prepaid healthcare obligations assumed by the provider under continuing-care contracts as calculated on an actuarially sound basis using reasonable assumptions for mortality and morbidity.

REQUIREMENTS BEFORE CONSTRUCTION

For providers that have not yet begun constructing facilities, the law prohibits construction from beginning until a minimum number of living units have been presold. Current law sets the minimum number to at least (1) one-half of the units in the facility or (2) if the construction is to be completed in stages, one-half of the units in the designated part of the planned facility that show financial feasibility. Under the bill, the minimum number is at least (1) one-half of the units in the facility or (2) 50% of any designated part or parts thereof as determined by DSS. The bill eliminates the (1) requirement that such units evidence feasibility through a written notice from the DSS commissioner stating that the provider has filed proof of committed construction financing or other documentation of financial feasibility deemed sufficient by the commissioner.

The law also requires that the provider has received a minimum deposit for all presold units. Under current law, the minimum deposit is the lesser of 5% of the entrance fee per unit for all presold units or $10,000 per unit for all presold units. The bill instead requires a minimum of $10,000.

Under the bill, these new requirements apply to contracts entered into after July 1, 2015.

ADDITIONAL CONTRACT SPECIFICATIONS

Refunds

By law, continuing care facility contracts must specify the terms and conditions under which the contracts may be cancelled by the provider or the resident, and the conditions for any refunds. The bill requires that, for contracts entered into after July 1, 2015, any refund must be

delivered to the resident or his or her estate within two years from the date the unit is vacated or sooner if contractual conditions for such refund have been met.

Periodic Charges and Recurring Fees

By law, the provider must include in the contract the manner in which the provider may adjust periodic charges or other recurring fees and any limitations of such adjustments. Current law requires that if there are no limits on such adjustments, the provider must include a clear statement that such increases may be made at the provider's discretion. For contracts entered into after July 1, 2015, the bill instead prohibits providers from increasing periodic charges or other recurring fees without providing the resident with 30 days advance written notice.

ESCROW REQUIREMENTS AND FINANCIAL DISTRESS

Connecticut Place of Business Requirement

By law, providers must establish an entrance fee escrow with a bank or trust company as escrow agent before soliciting or entering into any continuing care contract. Current law requires that if a prospective resident is a Connecticut resident when signing the contract, the bank or trust must be one that has its principal place of business in Connecticut. The bill instead requires all providers to use banks or trusts with a place of business in Connecticut.

Funds in Escrow and Reserve Requirement Calculations

The bill decreases the required amount providers must maintain in escrow. Current law requires providers to maintain enough funds in escrow to cover all principal and interest, rental, or lease payments due during the next 12 months on account of any mortgage loan or any other long-term financing of the facility. The bill decreases this requirement to six months. By law, the provider must also have enough in escrow to cover the total cost of operations of the facility for a one-month period, excluding such payments for debt service, rental payments, or lease payments.

The bill also allows providers to use funds in accounts for mortgage loans, bond indentures, or other long-term financing in their computation of required reserve amounts, provided such funds are available to make payments when operating funds are insufficient for these purposes. The bill also allows providers to apply cash amounts held pursuant to requirements for such loans, indentures, or financing toward the provider's computation of the required operating reserve amount. Under the bill, DSS may accept the terms or covenants regarding establishment or maintenance of reserve or escrow funds or financial ratios associated with such loans, indentures, or other long-term financing as an alternative to reserve provisions.

By law, entrance fee escrows may not be pledged as collateral or subordinated to other loans or commitments of any kind. The bill creates an exception to allow providers to pledge reserve fund escrows as collateral for a first mortgage loan or other long-term financing obligation of the facility.

Financial Distress and Remediation Plan

Under the bill, if a provider seeks modification, waiver, or extension of any of its material financial covenants or material payment terms under a mortgage loan, bond indenture, or other long term financing agreement, the provider must report such requests in writing to the DSS commissioner and provide a copy to the applicable residents council of the facility or facilities operated by the provider in the state, within seven business days of making the request. Under the bill, if DSS determines that a facility is in financial distress, the provider of that facility must propose a remediation plan to improve the provider's financial health. Under the bill, the provider must submit the plan for DSS approval and supervision and must disclose the plan to residents. The provider must file regular reports (quarterly or on an alternative schedule established by DSS) on its progress in meeting its approved remediation plan with DSS and the residents council.

ADVISORY COUNCIL

The bill requires the Advisory Committee on Continuing Care to

meet by August 1, 2015, and quarterly thereafter. It adds to the committee a DSS designee who must report to the DSS commissioner after every meeting on actions taken and recommendations made at the meeting.

By law, the committee assists continuing-care staff in its review and registration of functions and reports to the commissioner on developments in the field, any special problems associated with continuing care and concerns of providers and residents, and when appropriate, recommends changes in statutes and regulations.

BACKGROUND

Continuing-Care Contract

By law, a continuing-care contract is an agreement in which the provider furnishes a person care and shelter in a facility or care at home with the right to future access to care and shelter in a facility and medical or nursing services or other health-related benefits for the life of a person or for a period in excess of one year. By law, the agreement is to care for a person not related to the provider and requires a present or future transfer of assets or an entrance fee in addition to or instead of periodic charges.

Continuing Care Provider

By law, a continuing care provider is any person, corporation, limited liability company, business trust, trust, partnership, unincorporated association or other legal entity, furnishing care and shelter in a facility or care at home with the right to future access to care and shelter in a facility and other services under a continuing-care contract.

COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 16 Nay 0 (03/24/2015)